

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02923						02915					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Worcester</u> MARYLAND						a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STICKTON</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>					
c. LENGTH OF STAY IN 1b <u>6 MO</u>						d. STREET ADDRESS <u>231</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLLAND NURSING HOME</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>BESSIE DRYDEN DENNIS</u>						<u>FEB 16 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>SEPT. 12, 1879</u>				Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>SNOW HILL, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT JAMES DRYDEN</u>						14. MOTHER'S MAIDEN NAME <u>MARY ELLEN DAVIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-32-2469</u>		17. INFORMANT <u>WALTER C. DENNIS</u>				Address <u>NEWARK, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>491X</u> <u>Bronchopneumonia - Right lung</u>											
DUE TO (b) <u>7 days</u>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
Hour a.m. p.m. <u>19</u>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>Feb</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>Feb 16 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>David Rafat</u>											
22b. DATE SIGNED <u>2-17-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>											
22d. ADDRESS <u>SNOW HILL MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<u>BURIAL</u>			<u>2/17/67</u>			<u>BOWEN</u>			<u>NEWARK WOR. MD</u>		
24. FUNERAL DIRECTOR <u>Ann A. Burbage Berlin Md</u>						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
						DATE <u>FEB 23 1967</u> <u>Charles Judge</u>					

02323

05315

02323

HARRINGTON, Mrs. H. M.

BESSIE D. DENNIS

2021 12 18 87

HOUSING FOR OWNERS SHOW HILL, N. Y.

ROBERT JAMES DEYER

112 110 220 22-22-22 WATER K. DENNIS NEW YORK

State of New York

County of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G385 2/17/67 pc

02924

CERTIFICATE OF DEATH

02916

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>28 Burley St.</u>			d. STREET ADDRESS <u>BURLEY ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>H. LEE LYNCH</u>			4. DATE OF DEATH Month Day Year <u>FEB. 9 19 67</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 2, 1913</u>	9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>23-1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ADKINS Co</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>BERLIN MD RFD</u>	
13. FATHER'S NAME <u>JACOB LYNCH</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			14. MOTHER'S MAIDEN NAME <u>SALLIE QUILLIN</u>		
16. SOCIAL SECURITY NO. <u>218-14-3494</u>			17. INFORMANT Address <u>Mrs. H. LEE LYNCH BERLIN MD</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1966</u> , to <u>Feb 9 - 1967</u> , that (I) (we) last saw the deceased alive on <u>2-9-1967</u> , and that death occurred at <u>4:00 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Chas R Law</u>			22b. DATE SIGNED <u>2-11-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Berlin Md</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>
24. FUNERAL DIRECTOR <u>Anna A Burbage</u>			23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR. MD</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

01050

03254

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

02925

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02917

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Whaleyville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Whaleyville	
c. LENGTH OF STAY IN lb 3 years		d. STREET ADDRESS Route 1 Box 174 D	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 Box 174 D		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Roberts Meredith		4. DATE OF DEATH Month Feb. Day 9 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-08
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Roberts		14. MOTHER'S MAIDEN NAME Mabel Kirby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 146-16 2029	
17. INFORMANT Walter Meredith, husband, same.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) A.S.C.V.D. DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Francis J. Townsend, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Francis J. Townsend, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judas	
22. DATE SIGNED Feb. 9 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows		23d. LOCATION (City or Town) (County) (State) Burlington N.J.	
24. FUNERAL DIRECTOR Richard T. Watson		ADDRESS Selbyville, Del.	
25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judas	

1080

1080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02926					CERTIFICATE OF DEATH			02918	
1. PLACE OF DEATH a. COUNTY Worcester					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill (Rural)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill (Rural)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Ephriam Farm					d. STREET ADDRESS Mt. Ephriam Farm			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUSBY					First Middle Last * MOFFETT		4. DATE OF DEATH Month Day Year Feb. 7 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1909		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager			10b. KIND OF BUSINESS OR INDUSTRY Stock Farm		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Moffett					14. MOTHER'S MAIDEN NAME Wilhemina Lusby				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT Address Harold Stadham, Warwick, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO (b) ARTEROSCLEROTIC HEART DISEASE DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH MINUTE 3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASTHMATIC BRONCHITIS								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from AUG 1 , 19 62 to FEB 7 , 19 67 that (I) (we) last saw the deceased alive on FEB 7 , 19 67 , and that death occurred at 5:30 M, from causes and on the date stated above.									
22a. SIGNATURE Robert C. LaMar					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-9-67	
22c. PHYSICIAN'S NAME (Type) Robert C. LaMar, M. D.					22d. ADDRESS 10439 Snow Hill, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Shrewsbury Cem.		23d. LOCATION (City or Town) (County) (State) Kennedyville, Md			
24. FUNERAL DIRECTOR Edward Fellows					25a. REC'D BY REGISTRAR DATE FEB 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02927					02919				
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City 23-1				
c. LENGTH OF STAY IN 1b 8 years					d. STREET ADDRESS R.F.D. 2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. 2					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last SIDNEY LOUIS SOMERS			4. DATE OF DEATH Month Day Year February 8 1967						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Transit Co.		11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George T. Somers				14. MOTHER'S MAIDEN NAME Mary Ellen Mears					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs Olive T. Somers, Pocomoke City, Md.					
15. ADDRESS R.F.D. 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CVA DUE TO (b) Ca of lung DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1965, to 2/8/67, that (I) (we) last saw the deceased alive on 2/3 1967, and that death occurred at 7:45 AM, from the causes and on the date stated above.									
22a. SIGNATURE Isaac S. White				22b. DATE SIGNED 2-8-1967					
22c. PHYSICIAN'S NAME (Type) Isaac S. White, M.D.				22d. ADDRESS Bloxom, Virginia					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-1967		23c. NAME OF CEMETERY Wessells Cemetery		23d. LOCATION (City, town or county) (State) Accomack County, Virginia			
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR DATE FEB 10 1967					
				25b. REGISTRAR'S SIGNATURE Charles Judge					

020310

020317

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with several lines of text.]



[Illegible text follows, appearing to be a continuation of the memorandum or report, with several lines of text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02928						02920					
1. PLACE OF DEATH a. COUNTY <i>Worcester</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Worcester</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Snow Hill, Md.</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SNOW HILL</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>504 Dighton Ave.</i>						d. STREET ADDRESS <i>504 Dighton Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anthony</i>			First <i>Anthony</i>			Middle <i>Tilghman</i>			Last <i>Tilghman</i>		
5. SEX <i>M</i>		6. COLOR OR RACE <i>AA</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-6-1877</i>		9. AGE (In years last birthday) <i>89 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>Dryden Hatchery</i>		11. BIRTHPLACE (County & State, or foreign country) <i>High Point N.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Sandy Tilghman</i>						14. MOTHER'S MAIDEN NAME <i>Adeline</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>212-32-2481</i>		17. INFORMANT <i>Mattie Tilghman</i>		Address <i>Snow Hill, Md. 504 Dighton Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Congestive Failure</i> (c) <i>Arteriosclerotic Heart Disease</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>Yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>61</i> , to <i>Feb</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb 2</i> , 19 <i>67</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>David Lepv</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-5-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAPAT</i>						22d. ADDRESS <i>Snow Hill</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>2-11-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church of God in Christ</i>			23d. LOCATION (City, town or county) (State) <i>Snow Hill, Md</i>			
24. FUNERAL DIRECTOR <i>Golden Funeral Home</i>						ADDRESS <i>Snow Hill, Md</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05050

STREET, BALTIC
1210

2322

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

Handwritten text, possibly a name or address.

FOR STATE
HEALTH DEPT.

02929

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02921

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 2 - Rural Berlin</u>		c. LENGTH OF STAY IN lb <u>23-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Goldsbury Truitt Jr</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21 1932</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chicken Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>	9. AGE (In years last birthday) yrs. <u>34</u>
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Goldsbury Truitt</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-28-4308</u>	
17. INFORMANT <u>MRS Betty Lou Truitt (wife)</u>		Address <u>Same Address.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>976X</u> IMMEDIATE CAUSE (a) <u>Gunshot wound, head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INSTANT</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self through left temple - "pumpkin ball"</u>	
20c. TIME OF INJURY Month, Day, Year <u>832 Feb 12 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>R-2 Berlin WOR MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F J Townsend, Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F J Townsend, Jr</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, county) <u>Decatur, Ga</u>	
22. DATE SIGNED <u>Feb 13, 67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE</u>	23d. LOCATION (City or Town) (County) (State) <u>WILLARDSVILLE MD</u>
24. FUNERAL DIRECTOR <u>Anna A. Burdette</u>		ADDRESS <u>Berlin MD</u>	
25a. REC'D BY REGISTRAR <u>FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02930						CERTIFICATE OF DEATH			02922		
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b Pocomoke City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 Lindn Ave.						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 209 Lindn Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Edward Williams						4. DATE OF DEATH Month February Day 25 Year 1967					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1896		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm work		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Williams						14. MOTHER'S MAIDEN NAME Amonda ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212 56 1187		17. INFORMANT 209 Linda Ave. Mrs. Eva Dix Pocomoke City, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC CORONARY INSUFFICIENCY DUE TO (c) UNDETERMINED											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (county) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/24, 1966 , to 2/26, 1967 , that (I) (we) last saw the deceased alive on 2/25, 1966 , and that death occurred at 230 AM , from the causes and on the date stated above.											
22a. SIGNATURE Herville A. Baron						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2/27/67		
22c. PHYSICIAN'S NAME (Type) Pocomoke City, Md.						22d. ADDRESS Pocomoke City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/3/67		23c. NAME OF CEMETERY OR CREMATORY Wharton Cemetery			23d. LOCATION (City, town or county) (State) Parksley, Va.		
24. FUNERAL DIRECTOR Samuel S. Sargent						ADDRESS New Church, Va.			25a. REC'D BY REGISTRAR MAR 6 1967		
						25b. REGISTRAR'S SIGNATURE Charles J. Judge					

02330

02330

TRANSFER

1000000000

1000000000

John Adams

William

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

Handwritten signature

MAR 2 1957